DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF FARRAGUT, LLC	12823 KINGSTON PIKE KNOXVILLE, TN 37923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors to rrooms larger than 50 square feet, used to store combustible materials, were self-closing. The findings include: Observation and interview with the Maintenance Director, on February 23, 2015 at 8:10 a.m. confirmed room 304 was used to store combustibles and the corridor door was not provided with a door closer. (NFPA 101, 19.3.2.1 (7). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 029	How the correction will be accomplished on a temporary and permanent basis: 1. Oxygen Tanks were removed from room #304 on 2/24/15 and hazardous materials will no longer be stored in this room. 2. The Maintenance Director inspected all storage rooms on 2/24/15 and no other oxygen tanks were found in incorrect storage rooms. Potential to be affected: Any storage room without a door has the potential to be affected. No known direct or indirect harm identified to residents How corrective actions will be monitored to ensure actions will not reoccur: 1. Frequency: The Maintenance Director will do daily spot checks to ensure hazardous materials, including oxygen tanks, are not stored in rooms which are not approved for storage of hazardous materials. 2. Compliance: The Maintenance Director will immediately address and remove any hazardous materials upon finding in non-compliance. 3. Evaluation: Maintenance Director will bring results of the checks to each Safety Committee meeting. Safety Committee will make changes as necessary based on the reports of the Maintenance Director. Responsible party(s): 1. Maintenance Director	2/24/15
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] NHA 4/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APR 24 2015

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to ensure means of egress were maintained accessible at all times. The findings include: 1. Observation on February 23, 2015 at 8:00 a.m. confirmed 2 of 6 outside means of egress were not maintained slip resistant. The rear outside exits from the west station and Jamestown exit by room 421 had slush and ice on the sidewalk. (NFPA 101, 7.1.6.4) 2. Observation on February 23, 2015 at 8:28 a.m. confirmed the shower room across from room 403 was provided with locking device which was not operable from the egress side. Observation revealed a toggle bolt on the outside of the door. (NFPA 101, 7.2.1.5.1) These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 038	How the correction will be accomplished on a temporary and permanent basis: 1. Ice was removed from two entry ways affected. 2. Toggle Bolt was removed from door to bathroom Potential to be affected: Jamestown Residents, staff members, and visitors have the potential to be affected by ice around entryways. No known direct or indirect harm identified to residents. All doors have potential to be affected. How corrective actions will be monitored to ensure actions will not reoccur: 1. Entry doors will be pre-treated with salt when icing conditions are expected to occur. Maintenance Director will do walking checks during such conditions to ensure entryways are salted 2. Compliance: No less than 100% 3. Evaluation: Maintenance Director will bring results of the checks to each Safety Committee meeting. Safety Committee will make changes as necessary based on the reports of the Maintenance Director. Responsible party(s): 1. Maintenance Director	2/23/15
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046	How the correction will be accomplished on a temporary and permanent basis: 1. Emergency Exit Light replaced on 2/24/15. Potential to be affected: 1. No known direct or indirect harm identified to residents How corrective actions will be monitored to ensure actions will not reoccur:	2/24/15
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all			

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K 046	Continued From page 2 emergency lighting was operational. The findings include: Observation and interview with the Maintenance Director, on February 23, 2015 at 8:30 a.m. confirmed the battery-powered emergency light in the outside electrical room failed to work when tested. (NFPA 101, 7.8.1.4, 19.2.8) This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 046	1. Frequency - Emergency Lights will be check monthly and logged on a newly created log sheet. 2. Compliance - Replacement of non-functioning lights will occur after any noted failures in emergency lights. 3. Evaluation - Maintenance Director will bring the log sheet to Safety Committee meeting to ensure that the emergency light is functioning.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all means of egress were provided with directional signs. The findings include: Observation and interview with the Maintenance Director, on February 23, 2015 at 8:30 am confirmed the egress corridor from the west side of the Jamestown double doors was not provided with exit signage to indicate the direction of egress. (NFPA 101- 7.10.2., 19.2.10.1) This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 047	How the correction will be accomplished on a temporary and permanent basis: 1. Emergency Exit Sign installed on 2/26/15. Potential to be affected: 1. No known direct or indirect harm identified to residents How corrective actions will be monitored to ensure actions will not reoccur: 1. Frequency: Egress signs will be repaired and maintained as noted during monthly spot checks by the Maintenance Director. 2. Compliance: No less than 100% 3. Evaluation: Maintenance Director will note any repairs or maintenance needed on egress signs to the Safety Committee meeting. Safety Committee will make changes as necessary based on the reports of the Maintenance Director. Responsible party(s): 1. Maintenance Director	2/26/15

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K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridors in the means of egress were maintained clear of all obstructions The findings include: Observation and interview with the Maintenance Director, on February 23, 2015 between 8:10 am and 3:15 pm confirmed the egress corridor by the west nurses station, outside the Jamestown double doors, were obstructed with 2 Hoya lifts and a bedside table. (NFPA 101- 7.1.10.2.1.) This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 072	<u>How the correction will be accomplished on a temporary and permanent basis:</u> 1. Hoyer Lifts and bedside table were removed from hallway by Maintenance Director on 2/23/15 2. No other items were stored in the hallways when Maintenance Director performed walking rounds on 2/23/15. 3. All staff were in-serviced on items being stored in the hallway by 3/23/15 <u>Potential to be affected:</u> 1. No known direct or indirect harm identified to residents <u>How corrective actions will be monitored to ensure actions will not reoccur:</u> 1. Frequency: Maintenance Director will perform audits three times a week for four weeks. All staff will perform ongoing walking rounds to ensure compliance and will remove any items being stored in the hallway upon recognition. 2. Compliance: Any items found to be stored in the hallway out of compliance will be remove at that time and placed in the appropriate area. 3. Evaluation: Maintenance Director will bring audits to the Safety Committee meeting. Safety Committee will make <u>Responsible party(s):</u> 1. Maintenance Director	2/23/15 3/23/15
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical components complied with the National Electrical	K 147		

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K 147	Continued From page 4 Code, NFPA 70. The findings include: 1. Observation and interview with the Maintenance Director, on February 23, 2015 at 11:15 am confirmed the main electrical room had boxes of combustibles in front of them. (NFPA 70,110-16 (d). 2. Observation and interview with the Maintenance Director, on February 23, 2015 at 11:30 am confirmed the electrical box above the ceiling in Jamestown by the Med room and the electrical outlet by the door inside the main electrical room were not provided with covers. (NFPA 70, 314.28 (C). These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 23, 2015.	K 147	How the correction will be accomplished on a temporary and permanent basis: 1. Combustible boxes were immediately removed from the electrical room. 2. Electrical covers were immediately replaced on noted electrical boxes. 3. All electrical boxes were inspected in the building by the Maintenance Director on 2/27/15. Potential to be affected: 1. No known direct or indirect harm identified to residents How corrective actions will be monitored to ensure actions will not reoccur: 1. Maintenance Director will cover any electrical box that he performs work on and will inspect the work of any outside contractor doing electrical repairs 2. Maintenance Director will inform Administrator immediately and report to the Safety Committee any time any non-compliance is noted. Responsible party(s): 1. Maintenance Director 2. Administrator	2/23/15 2/27/15